June 2014 Indiana State Cancer Registry Education News

Save the Dates: August 4, 2014 Coding Workshop on Directly Assigning Stage
November 6 & 7, 2014 ICRA Fall Conference

The August workshop will be held in Rice Auditorium at the State Department of Health. An announcement will be sent out soon. Laura Ruppert, the Cancer Surveillance Section Director, Indiana State Cancer Registry (ISCR), has worked with the State IT department in order to have the workshop taped for later posting on the State's Web site. The details of this are still being worked out.

Collaborative Stage Transition
The standard setters are finalizing plans for the transition from Collaborative Staging (CS) to directly assigned AJCC TNM stage and SEER Summary Stage (SS). The final revisions are to be submitted by December 1, 2014. NAACCR Standards Volume II will be released July 1, 2015 and the EDITS Metafile is to be released September 1, 2015. The requirement for directly assigned AJCC TNM stage will be effective for cases diagnosed January 1, 2016 and later. Education and training will be ongoing. The American Joint Committee on Cancer (AJCC) will provide ongoing education on directly assigned AJCC stage. There are a number of free educational activities on their Web site: www.cancerstaging.org.

CS will continue to be collected for 2014 and 2015 diagnoses and requires conversion to CS v 02.05. NPCR, SEER, CoC and other work groups are working through NAACCR to determine the preferred method of collection and transmittal of data currently collected in CS.

2015
NPCR (and the State Registry) will require directly coded SS (in addition to CS) beginning with cases diagnosed January 1, 2015. Summary Stage categorizes how far cancer has spread from the point of origin combining clinical and pathologic documentation. SEER recommends that the updated Summary Stage Manual on their Web site be used, rather than the Summary Stage Manual - 2000. It can be found at the following link: http://www.seer.cancer.gov/tools/ssm/.

2016
NPCR (and the State Registry) will require directly coded SS; Clinical T, N, M for all cases; and Pathologic T, N, M for eligible cases. AJCC 7th edition will be used until 2017. On June 17, 2014, the CS Transition Group agreed to continue collecting the CS Site-Specific Factors (CS SSF), as specified by the applicable standard setters, using the current NAACCR record layout and definitions at least through 2016. This will allow time to evaluate the CS SSFs and how to structure their collection within the NAACCR layout. It will also accommodate prognostic indicators in the AJCC 8th edition.

FORDS
The FORDS Revision project is underway. The CoC is in the process of revising the FORDS manual. Until September 2014, anyone can submit suggestions on fields and data items that one would like to see made clearer or ones where new codes would be helpful. As we abstract sometimes we see first-hand where some of the coding options could be more useful and or defined better. This is a chance to give ideas before they finalize the latest revision. Submit suggestions by going to the following link: http://www.facs.org/cancer/coc/fordsrevision.html.

There are options to change, add or delete an item. They ask for examples of scenarios to provide the rationale for the change. They also ask for your contact information in case they need clarification from you. The contact information will not be disseminated.

RQRS
The Rapid Quality Reporting System (RQRS) has replaced the CoC standard for "Timeliness." Cases should not be submitted to the State, however, until they are complete. Facilities that use RMCDS software should put the cases in suspense until they are complete. Cases in suspense can be reported to the RQRS, but are not included in State submissions. Those who use other software should contact the vendor for a method to prevent submission of incomplete cases to the State Registry.

TEXT
Text documentation is required and should be complete enough that the case could be abstracted from it. Text should be complete enough that the source document (medical record) does not have to be reviewed again in the case of an audit, for questions from a physician, for questions from the State registry, or for the need to recode items because of changes in reporting requirements.

SEER Web-Based Education
SEER has a new education portal at the following URL: https://educate.fhcrc.org
There are case scenarios that can be abstracted. The answers with rationale are then provided when finished. Beginning June 23, SEER is adding a "TNM Training" series. Cases scenarios from fourteen sites will be available to facilitate learning of directly assigned AJCC stage. CE's are also available. This is a free education tool. This application is supported only by Firefox and Chrome browsers. One must register to access the training modules. The training modules are labeled, "practical application tests."

Grade for 2014
The standard setters have collaborated to consolidate and clarify the coding rules for grade (NAACCR item #440, Grade, Differentiation or Cell Indicator) for cases diagnosed January 1, 2014 and forward. The "Instructions for Coding Grade for 2014+" can be found at the following link: **http://seer.cancer.gov/tools/grade/.** Please save a copy of these instructions as your reference for accurately coding grade for cases diagnosed 2014 and forward.

SEER*RX – Interactive Antineoplastic Drug Database
This was updated Aug. 6, 2013. Please use this to determine how systemic treatment should be coded. Check the SEER Web site periodically to determine any updates.

Hematopoietic and Lymphoid Neoplasm Database (Heme DB) and Coding Manual
To view and/or download the Hematopoietic Database Software Version 2.3.1 go to the SEER at: http://www.seer.cancer.gov/tools/heme/. The latest version was updated January 21, 2014. The Heme DB coding manual is the reference source for the hematopoietic and lymphoid neoplasms (9590/3-9992/3) diagnosed January 1, 2010 and forward. The Heme DB should be used as a screening tool to assist in determining reportability. The Coding Manual should be used for reportability instructions and rules for determining the number of primaries, primary site, histology and cell lineage or phenotype. The 2014 release of the Heme DB has consolidated all the information from the 2010 and 2012 Databases. As with SEER*Rx, this DB can be downloaded or used on-line. It is important to check with the Web site periodically to know when it has been updated.

2014 CTR Exam Dates
October 18-November 8: Application deadline is September 19.

The 2014 CTR Exam Handbook and Application can be found at:
http://www.ncra-usa.org/files/public/CTRExamHandbook2014.pdf

Coding Tips
1. Are patients with benign CNS tumors to be followed by CoC approved centers? All Class 10's and 20's are to be followed by CoC approved centers.

2. Gleason Conversion Table for Prostate Cancer (revised for cases diagnosed 2014 and forward)

Grade Code	Gleason Score (sum of primary & secondary patterns)
1	2, 3, 3, 4, 5, or 6
2	7
3	8, 9, or 10

3. Distant Mets for Unknown Primary Site
CS Version 02.05 clarified that for unknown primary site, code 8 should not be used in the fields for distant mets of bone, brain liver and/or lung. The valid codes for those items in an unknown primary are 0, 1, or 9.

4. Distant Mets for Mycosis Fungoides, Sezary Syndrome, or Ocular Adnexal Lymphoma
CS Version 02.05 clarified that for the histologies identified above, code 8 should not be used in the fields for distant mets of bone, brain liver and/or lung.

5. Code the six drugs listed below as BRM, beginning with January 1, 2013 diagnoses. Continue to code cases diagnosed prior to 01/01/2013 as chemotherapy.

   Alemtuzumab/Campath
   Bevacizumab/Avastin
   Rituximab/Rituxan
   Trastuzumab/Herceptin
   Pertuzumab/Perjeta
   Cetuximab/Erbitux

6. Lupron, a hormone used for prostate cancer, is also used for certain breast cancers and is to be coded as hormone.

7. Denosumab (Xgeva) is FDA approved for unresectable giant cell tumors of bone. Code to BRM/Immunotherapy for this type of tumor. Do not code if given for prevention of bone mets from solid tumors or as an osteoclastogenesis inhibitor for Multiple Myeloma.

8. Small Lymphocytic Lymphoma (SLL): Beginning with January 1, 2012 diagnoses, code 9670/3 is obsolete. It is felt that SLL is the same disease as Chronic Lymphocytic Leukemia (CLL). Assign code 9670/3 only for cases diagnosed prior to 01/01/2012. For cases diagnosed January 1, 2012 and forward, code SLL to 9823/3.

9. Melanoma (skin C44.0-C44.): Regressing melanoma (8723/3) is a histologic type. It should only be coded if noted as such on the pathology report. Regression, which is coded in CS SSF 8, is not the same thing. Regression is found on the path report in relation to the radial growth phase.

10. Intestinal type adenocarcinoma is a histology that usually occurs in the stomach. If this histology is diagnosed in a colon site, see MP/H rule H3 and code to adenocarcinoma, NOS (8140/3).

11. Meningiomas arise in the meninges. For benign CNS tumors, code meningiomas to C70._, not C71._. If diagnosed in an intracranial site, assign code C70.0, not C70.9.

12. Code papillary serous carcinoma of the ovary or endometrium to 8460/3. Do not assign the “mixed” code 8323/3. The wording is important. Papillary serous carcinoma is not the same as papillary **and** serous carcinoma, which is coded to the “mixed” code 8323/3 when diagnosed in a gynecologic site.

13. Code micropapillary carcinoma of the thyroid to 8260/3, not 8341/3. "Micro" indicates an amount not the histology.
    Code papillary carcinoma of the thyroid to 8260/3, not 8050/3. See ICD-O-3 page 75 for synonyms under code 8260/3.

14. Code pituitary adenoma to 8272/0, not 8140/0.

15. Code 5-FU and Leucovorin as single agent chemotherapy (code 02). Leucovorin is an ancillary agent and not coded.

16. Lymphovascular Invasion (LVI):
    - Assign LVI code 0 for all in-situ cases.
    - Assign LVI code 9 for all unknown primaries.
    - Assign LVI code 8 for all lymphoma/hematopoietic diagnoses (histology codes 9590/3-9992/3).

17. It is important to open your manuals and look up codes. Software look-ups do not always give enough information for the best code to be assigned.